**Mathis Independent School District**
**410 East San Patricio Ave.**
**Mathis, Texas 78368**
**PH: (361) 547-3378**

# Employee Request for Reasonable (ADA) Accommodation
# Certification of Health Care Provider

1. The purpose of this form is to assist the employee to initiate a request for an accommodation under the Americans with Disabilities Act (1990). As a part of this evaluation, information is required regarding the employee's disability, essential job functions, applicable functional limitations and the doctors recommended accommodation(s).
2. **INSTRUCTIONS to the EMPLOYEE:** Please have your health care provider complete the form and return to the Human Resources Department within 15 calendar days. EMAIL: jencinia@mathisisd.org; FAX: ( 361) 678-2063

**General Information** *(please print)*

Name (Last, First, MI) _____ ID# _____ Phone# _____

Job Title _____ Department/Location _____

**Instructions to the Health Care Provider:** Your patient has requested an accommodation due to their health condition. Please answer, (fully and completely), all applicable parts. Be as specific as you can; terms such as "lifetime, "unknown," or "indeterminate" may not be sufficient to determine whether the employee qualifies for an accommodation.

Provider's Name & Address: _____

Telephone #: _____

**Does the employee have a disability that substantially limits one or more major life activities?**
Yes☐ No ☐ *If No, please proceed to Medical Professional's Signature line to sign, date and return.*

**Describe the nature of the disability (physical or mental impairment):**

_____
_____
_____

**Specify the limitations to performing the essential functions of the job: *(Job Description Attached)***

_____
_____
_____

**Specify the type of recommended accommodation(s). Be as specific as possible. (*Lifting, walking, etc*):**

_____
_____
_____

**Specify the duration recommended of the accommodation(s):**

_____

**Please provide date of the next follow-up:** _____

*I certify that the information provided by me in this certification is true and correct.*

Medical Professional Signature: _____ Date: _____


*Mathis ISD prohibits discrimination, including harassment, against any employee/student on the basis of race, color, religion, gender, national origin, age, disability, or any other basis prohibited by law. Retaliation against anyone involved in the complaint process is a violation of District Policy and is prohibited.*